Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

www.dmas.virginia.gov

MEDICAID MEMO

TO: All Physicians, Nurse Practitioners and Health Department Clinics furnishing Primary Care Services and participating in the Virginia Medical Assistance Program, Managed Care Organizations providing services to Virginia Medicaid members

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services

MEMO: Special

DATE: 12/28/2012

SUBJECT: Higher Payments for Medicaid Primary Care Services — Effective January 1, 2013 thru December 31, 2014

As part of the Affordable Care Act, Medicaid agencies and Medicaid managed care plans are required to pay Medicare rates for Medicaid primary care services furnished by eligible physicians in calendar years 2013 and 2014. This requirement does not apply to reimbursement for services furnished FAMIS members. This Medicaid Memo discusses the requirements in the final rule published by the Centers for Medicare and Medicaid Services (CMS) in the November 6, 2012 Federal Register and the procedures to be followed in Virginia to implement the higher payment for Medicaid primary care services. DMAS and the Medicaid managed care plans will make these higher payments for dates of service on or after January 1, 2013, but full implementation will take several months. The first step is to determine eligible physicians through a process of self-attestation, which is described in detail in the section below on provider self-attestation. The remainder of the memo covers other aspects of the implementation in as much detail as is known at this time. DMAS will follow up with additional information when it is known. Providers can find additional information as it is posted to the DMAS web portal at www.virginiamedicaid.dmas.virginia.gov. There is a link to additional information about the Medicaid primary care rate increase on the left hand side of the welcome page. In addition, physicians should expect additional guidance from Medicaid MCOs.

PROVIDER SELF ATTESTATION

States must make increased payments for services furnished by a physician, or under the personal supervision of a physician with a specialty designation of family medicine, general internal medicine or pediatric medicine or a related subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA). There is a list of specialties and subspecialties recognized by the various boards attached to this memo.

Physicians eligible for the primary care rate increase are required to complete the attached Certification and Attestation for Physician Primary Care Rate Increase form and submit it via fax or mail to the Virginia Medicaid Provider Enrollment Services Unit for processing. Eligible physicians must attest to a specialty designation of family medicine, general internal medicine and pediatrics or subspecialty and one of the following criteria below in order to receive the higher reimbursement rates for E&M services:

1. That they are a board certified physician with a specialty designation of family medicine, general internal medicine or pediatric medicine or a related subspecialty recognized by the ABMS, ABPS or AOA and/or

2. That they have furnished evaluation and management services and vaccine administration services that equal at least 60% of the Medicaid codes billed during the most recently completed calendar year or, for newly eligible physicians, the prior month.

According to CMS guidance, it is possible that a physician might maintain a particular qualifying board certification but might actually practice in a different field. A physician who maintains one of the eligible board certificates, but actually practices in a non-eligible specialty should not self-attest to eligibility for higher payment. Similarly, a physician board certified in a non-eligible specialty (for example, surgery or dermatology) who practices within the community as, for example, a family practitioner could self-attest to a specialty designation of family medicine, internal medicine or pediatric medicine and a supporting 60% claims history. In either case, should the validity of that physician's self-attestation be reviewed by the state as part of the annual statistical sample, the physician's payments would be at risk if the agency finds that the attestation was not accurate.

Processing of the attestation form may take up to ten business days from the date of receipt, and must be faxed or mailed to the Virginia Medicaid Provider Enrollment Service Unit's fax number and mailing address listed at the bottom of the Certification and Attestation for Physician Primary Care Rate Increase form. Please check www.virginiamedicaid.dmas.virginia.gov for the processing status of your attestation form.

All physicians who attest on or before March 31, 2013 will be eligible for higher payments for dates of service on or after January 1, 2013. After that date, physicians will be eligible for higher payments for dates of service on or after the beginning of the month of self-attestation. The date of attestation will be based on the date received if mailed or the fax date if faxed. See section on Fee-For-Service Payment Process for more information on payments of the higher rates.

At the end of CY 2013 and 2014, the Medicaid agency must review a statistically valid sample of physicians who received higher payments to verify that audited physicians meet the requirements for higher payments. Higher payments for both FFS and MCO services will be recovered from physicians who the audit determines were not eligible. When auditing physicians who have attested they are eligible based on a primary care claims history, DMAS will include all Virginia Medicaid claims paid by FFS and managed care plans.

The CMS final rule also indicates that primary care services furnished by nurse practitioners or physician assistants are eligible for higher payment if furnished "under the personal supervision of an eligible physician." DMAS has not yet determined how to verify that primary care services furnished by nurse practitioners and physician assistants are eligible for higher payments. DMAS also has not yet determined if primary care services billed through a Health Department Clinic are eligible for the higher payment and what attestation process would be required. DMAS will communicate additional information when these questions have been answered.

DMAS will share the attestations of DMAS enrolled providers with Medicaid MCOs who will make higher payments to all DMAS enrolled providers who attest through the process described above. Each MCO is responsible for contacting its contracted physicians who are not enrolled with DMAS and make available a similar attestation process for them.

MEDICARE PRIMARY CARE FEE SCHEDULE

For eligible providers, the services eligible for the payment increase include evaluation and management (E&M) procedure codes between 99201 and 99499, and vaccine and toxoid administration procedures. DMAS is only required to pay the higher rates on Medicaid covered codes in the E&M range. The higher rates do not apply to services furnished FAMIS members.

As directed in the CMS final rule, DMAS is developing the rates for the E&M procedure codes based on 100 percent of the Medicare fee schedule under the options specified in the rule. Specifically, the rates will reflect the calendar year (CY) 2013 Medicare relative value units in effect on January 1, 2013 and the CY 2009 conversion factor. DMAS is required to use this fee schedule because this fee schedule is higher than the current 2013 Medicare fee schedule in effect on January 1, 2013. DMAS will not adjust the fee schedule during CY 2013. DMAS has two other rate options. For E&M services that have a rate differential for site of service, DMAS can pay either the Medicare "site of service" differential rates or always pay the office rate. DMAS will always pay the office rate. DMAS also may pay separate rates for Northern Virginia and Rest of State, similar to Medicare policy or statewide rates based on a weighted average. DMAS will pay separate rates for Northern Virginia and Rest of State.

The rates for vaccine and toxoid administration for eligible providers will increase from $11.00 per administration of a vaccine or toxoid to $21.24, which is the Vaccines for Children (VFC) regional maximum amount specified in the CMS final rule. DMAS requires providers to use different procedure codes for vaccine administration than the codes covered in the CMS final rule. DMAS will pay the higher rate on the current procedure codes used for vaccine administration and there will be no change to billing for vaccine administration.

FEE-FOR-SERVICE PAYMENT PROCESS

DMAS will not pay higher rates on claims. Higher payments for Medicaid fee-for-service claims will be made in the form of lump sum quarterly supplemental payments. The higher payment amounts will be calculated on a paid claim line basis for the eligible providers who have completed the attestation. DMAS expects the first payment will be made in April for the first quarter but no payments will be made until DMAS receives approval of the State Plan Amendments related to these higher payments. Lump sum payments will be included on the remittance and DMAS will prepare detailed supplemental claim summary reports. More information will be provided later.

MANAGED CARE

DMAS pays Managed Care Organizations (MCOs) a monthly capitation payment for each eligible member enrolled in the MCO. DMAS will calculate the required increase in capitation payment to MCOs actuarially determined to be sufficient to cover the cost of MCOs paying eligible physicians the Medicare rate for E&M and vaccine administration services.

The Act requires that eligible physicians receive direct benefit of the payment increase for each of the primary care services specified in this rule. This requirement must be met regardless of whether a physician is part of a group, salaried, or receives a fee for service or capitated payment from the MCO. MCOs will provide assurances that the higher payment will actually be passed on for services furnished by the primary care physicians designated in statute. The structure of the MCO's provider network does not mitigate this responsibility.

MCOs will contact physicians in their networks about attestation and payments based on contract amendments, which have not been finalized.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, check status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Helpdesk, toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access service authorization information, including status, via KePRO's Provider Portal at http://dmas.kepro.org/.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

Attached Number of Pages: (2)

Primary Care Specialties and Subspecialties Recognized by the Various Boards

Subspecialists that qualify for higher payment are those recognized by the American Board of Medical Specialties (ABMS), American Board of Physician Specialties (ABPS) or American Osteopathic Association (AOA). For purposes of the rule, "General Internal Medicine" encompasses "Internal Medicine" and all recognized subspecialties. The websites of these organizations currently list the following subspecialty certifications within each specialty designation:

American Board of Medical Specialties (ABMS)

Family Medicine – Adolescent Medicine; Geriatric Medicine; Hospice and Palliative Medicine; Sleep Medicine; Sports Medicine

Internal Medicine – Adolescent Medicine; Advanced Heart Failure and Transplant Cardiology; Cardiovascular Disease; Clinical Cardiac Electrophysiology; Critical Care Medicine; Endocrinology, Diabetes and Metabolism; Gastroenterology; Geriatric Medicine; Hematology; Hospice and Palliative Medicine; Infectious Disease; Interventional Cardiology; Medical Oncology; Nephrology; Pulmonary Disease; Rheumatology; Sleep Medicine; Sports Medicine: Transplant Hepatology.

Pediatrics – Adolescent Medicine; Child Abuse Pediatrics; Developmental-Behavioral Pediatrics; Hospice and Palliative Medicine; Medical Toxicology; Neonatal-Perinatal Medicine; Neurodevelopmental Disabilities, Pediatric Cardiology; Pediatric Critical Care Medicine; Pediatric Emergency Medicine; Pediatric Endocrinology; Pediatric Gastroenterology; Pediatric Hematology-Oncology; Pediatric Infectious Diseases; Pediatric Nephrology; Pediatric Pulmonology; Pediatric Rheumatology, Pediatric Transplant Hepatology; Sleep Medicine; Sports Medicine.

American Osteopathic Association (AOA)

Family Physicians – No subspecialties

Internal Medicine – Allergy/Immunology; Cardiology; Endocrinology; Gastroenterology; Hematology; Hematology/Oncology; Infectious Disease; Pulmonary Diseases; Nephrology; Oncology; Rheumatology.

Pediatrics – Adolescent and Young Adult Medicine, Neonatology, Pediatric Allergy/immunology, Pediatric Endocrinology, Pediatric Pulmonology.

American Board of Physician Specialties (ABPS)

The ABPS does not certify subspecialists. Therefore, eligible certifications are: American Board of Family Medicine Obstetrics; Board of Certification in Family Practice; and Board of Certification in Internal Medicine. There is no Board certification specific to Pediatrics.

COMMONWEALTH OF VIRGINIA
Department of Medical Assistance Services

Certification and Attestation for Physician Primary Care Rate Increase Form-Fee for Service

Section I: Provider Information		
PROVIDER NAME	PROVIDER NPI NUMBER	
CONTACT NAME	CONTACT PHONE NUMBER	CONTACT E-MAIL ADDRESS

Section II: Information & Attestation

Section 1902(a)(13)(C) of the Social Security Act requires States to pay Medicare rates to physicians with a primary specialty designation of family medicine, general internal medicine or pediatric medicine for evaluation and management (E&M) services (CPT codes 99201 thru 99499) or vaccine administration services furnished to a Medicaid member in Calendar Years 2013 and 2014.

States must make increased payments for services furnished by a physician, or under the personal supervision of a physician who self-attests to a specialty designation of family medicine, general internal medicine or pediatric medicine or a related subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA), and then attests that he/she

1. Is Board Certified with such a specialty or subspecialty; or

2. Has furnished Evaluation and Management services (CPT codes 99201 thru 99499) and vaccine administration services that equal at least 60% of the Medicaid codes he or she has billed during the most recently completed calendar year or, for newly eligible physicians, the prior month.

Physicians should check the appropriate attestation below. Before attesting, physicians should review additional guidance regarding attestation in the Medicaid Memo dated December 28, 2012. A physician who maintains one of the eligible board certificates, but actually practices in a non-eligible specialty should not self-attest to eligibility for higher payment. Similarly, a physician board certified in a non-eligible specialty (for example, surgery or dermatology) who practices within the community as, for example, a family practitioner could self-attest to a specialty designation of family medicine, internal medicine or pediatric medicine and a supporting 60% claims history. At the end of CY 2013 and 2014, the Medicaid agency must review a statistically valid sample of physicians who received higher payments to verify that they meet the requirements.

☐ I attest to a specialty designation of family medicine, general internal medicine or pediatric medicine and I have a board certification in family medicine, general internal medicine or pediatric medicine or related subspecialty recognized by the ABMS, ABPS or AOA.

☐ I attest to a specialty designation of family medicine, general internal medicine or pediatric medicine and I have furnished E&M and vaccine administration services described in the federal rule that equal at least 60% of the Medicaid codes billed during the most recently completed calendar year or, for newly eligible physicians, the prior month.

Signature	*Printed Signature*	*Date*

Please allow up to 10 business days for processing. Please check www.virginiamedicaid.dmas.virginia.gov for processing status of your attestation form. This form can be faxed or mailed to Virginia Medicaid Provider Enrollment Services at the following fax number or address.

Toll free 888-335-8476 (Fax)
Virginia Medicaid Provider Enrollment Services
PO Box 26803
Richmond, VA 23261-6803
Phone: 888-829-5373